LEAVE TRANSFER REQUEST WORKSHEET

Agency:_____

Employee:_____

Employment Date:_____

Sick leave used for current disability: _____ hours

Annual leave used for current disability: _____ hours

Date all paid leave was exhausted: _____

First day of leave without pay: _____

Statement describing catastrophic or medical emergency of prolonged period without pay: Yes _____ No _____

Inclusive dates of disability: From _____ To _____

Inclusive dates of leave request: From _____ To _____

Leave request, minus holidays, equals 30 workdays: Yes _____ No _____

Physician verification attached: Yes _____ No _____

Are there other paid leave benefits for which the employee is eligible? Yes _____ No _____

If yes, which of the following.

Workers' Compensation?_____ Eligibility date _____

Long-term disability? _____ Eligibility date _____

Other?_____ Eligibility date _____

Official request from agency with authorizing signature: Yes _____ No _____

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